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No. 09-80

Supreme Court, U.S.
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In The

Supreme Court of the United States

GEORGE SCHOEDINGER, M.D., *et al.*,

Petitioners,

v.

UNITED HEALTHCARE OF THE MIDWEST, INC.,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

RESPONDENT UNITED HEALTHCARE OF THE MIDWEST, INC.'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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RULE 29.6 STATEMENT

Respondent United HealthCare of the Midwest, Inc., is a wholly-owned subsidiary of United Healthcare, Inc., which is a wholly-owned subsidiary of United HealthCare Services, Inc., which is a wholly-owned subsidiary of UnitedHealth Group Incorporated. There is no publicly held corporation that owns ten percent or more of the stock of United HealthCare of the Midwest, Inc.

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STATEMENT OF THE CASE

Petitioners' statement of the case contains numerous factual assertions that are false and either unsupported by the record or contrary to Petitioners' stipulation of facts in the district court. Indeed, Petitioners include several false factual assertions without any citation to the record whatsoever. Accordingly, Respondent submits the following statement of the case.

A. The facts

The Petitioners in this case are George Schoedinger, M.D. ("Dr. Schoedinger"), and Signature Health Services, Inc. ("Signature"). Signature is a corporation that employs physicians in a number of fields, including orthopedics, obstetrics and gynecology, physiatry, radiology, and allergy. Petitioners' Appendix ("Pet. App.") 33a; United's Appendix ("United's App."), ¶ 1.[1] Dr. Schoedinger is an orthopedic surgeon employed by Signature. Pet. App. 33a; United's App. ¶ 2. Dr. Schoedinger has authorized Signature to bill and collect on his behalf for the medical services that he provides to his patients. Pet.

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[1] United's Appendix to this Brief in Opposition consists of the parties' Joint Stipulation of Uncontested Facts that was filed in the district court and was found at pages 53-61 of the separate appendix that United filed with the court of appeals. Citations to "United App. ¶ ___" are to the paragraphs of this Joint Stipulation of Uncontested Facts.

App. 33a-34a; United's App. ¶ 3. Defendant-Respondent United Healthcare of the Midwest, Inc. ("United"), is a corporation that administers health plans sponsored by various employers. Pet. App. 34a; United's App. ¶¶ 4-5.

Before April 15, 2003, Dr. Schoedinger had a contract with United to be a "participating" or "in-network" provider for United. Pet. App. 34a.; United's App. ¶¶ 10-11. Under this contract, Dr. Schoedinger agreed to accept a set, agreed-upon amount as payment in full for services he rendered to patients covered under health plans administered by United. Pet. App. 34a; United's App. ¶¶ 11. Dr. Schoedinger terminated his provider agreement with United effective April 15, 2003, and has had no written contract with United since that time. Pet. App. 34a; United's App. ¶¶ 12-14. Therefore, since April 15, 2003, Dr. Schoedinger has been an "out of network" or "nonparticipating" provider with respect to United. *Id.*

After his termination of his provider agreement with United, Dr. Schoedinger (through Signature) submitted numerous benefit claims to United for services that he rendered to patients covered under health plans administered by United. Pet. App. 34a; United's App. ¶ 15. These patients assigned their benefits under their health plans to Dr. Schoedinger, and Dr. Schoedinger submitted benefit claims to United based on his status as an assignee. United's App. ¶¶ 15-16.

Petitioners' lawsuit concerns United's processing of 295 benefit claims that Dr. Schoedinger (through Signature) submitted for services that he provided to patients in plans administered by United. Pet. App. 33a-38a; United's App. ¶ 17. Two hundred eighty-nine of these 295 benefit claims arose under health plans covered by and subject to the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.* Pet. App. 37a; United's App. ¶¶ 19-20. The remaining 6 benefit claims arose under health plans not covered by ERISA. Pet. App. 37a; United's App. ¶ 21.

Of the 289 benefit claims arising under ERISA health plans, 268 arose under plans that are self-funded or self-insured. Pet. App. 37a; United's App. ¶ 22. This means that the employers sponsoring the plans were financially liable for the benefits due to plan participants, and United's sole role was to perform third-party administrative and claims-processing services in accordance with the terms of the plans and United's administrative services agreements with the plan sponsors. *Id.* The remaining 21 ERISA benefit claims were fully-insured by United, meaning that United was financially responsible for the benefits due to plan participants. Pet. App. 37a-38a; United's App. ¶ 23.

Most of the 295 benefit claims at issue involved patients who were railroad employees or their dependents and who were covered by the railroad health plans. United's App. ¶ 24. These railroad health plans are self-funded ERISA plans. *Id.* ¶ 25.

United provides third-party administrative and claims-processing services for the railroad health plans pursuant to its administrative and managed care services agreements with the railroad health plans. *Id.* While United pays benefit claims arising under the railroad health plans, it does so on behalf of the railroad health plans, which, as self-funded plans, are ultimately liable for the benefit claims. *Id.* ¶ 26.

The railroad health plans have a separate contract with a company called Coalition of America, Inc. ("Coalition"). United's App. ¶ 32. Coalition has agreements with a number of entities that maintain provider networks. *Id.* ¶ 27. These entities negotiate agreements with various healthcare providers whereby the providers agree to provide services at discounted rates. *Id.* ¶¶ 28-29. These entities effectively "rent" their provider networks to Coalition, and, in turn, Coalition makes these "rented" provider networks available to health plans (such as the railroad plans) that utilize Coalition's services. *Id.* ¶¶ 30-31.

The contract between Coalition and the railroad health plans did not come through United. United's App. ¶¶ 32-34. Coalition approached the railroad health plans, and the railroad health plans entered into the contract with Coalition without seeking the consent or approval of United. *Id.* United has no contractual relationship or dealings with Coalition other than through United's processing of benefit claims arising under the railroad health plans, discussed below. *Id.* ¶ 34.

If a patient covered under the railroad health plans obtains medical services from a United in-network provider, then United pays the benefit claim in accordance with the fee provisions of its provider agreement with the in-network provider, subject to the terms of the railroad health plans. United's App. ¶ 36. Under such circumstances, the benefit claim is not sent to Coalition for pricing. *Id.* ¶ 37.

If a patient covered under the railroad health plans obtains medical services from an out-of-network provider, however, United first determines whether benefits are payable under the railroad health plans. United's App. ¶ 38. If so and the benefit claim meets certain criteria (primarily, that the benefit claim exceeds $100), then United is required by its agreements with the plans to send the benefit claim to Coalition for pricing of the benefit claim. *Id.* If Coalition has access to a "rented" provider network under which it can invoke a discount, Coalition so advises United and tells United the amount of the discount and allowable charge for the benefit claim. *Id.* ¶ 39. United is then required by the railroad health plans to pay the benefit claim based on and in reliance on the pricing information that it receives from Coalition, subject to the terms of the railroad health plans. *Id.*

For most of the 295 benefit claims at issue in Petitioners' lawsuit, United initially processed the benefit claims incorrectly and did not pay Petitioners the full amount of benefits due under the patients' health plans for the benefit claims. Pet. App. 57a;

United's App. ¶ 44. For some claims, this was because United's computer system incorrectly continued to treat Dr. Schoedinger as a United in-network provider after he terminated his participating provider agreement effective April 15, 2003. United's App. ¶ 45. Other errors occurred because United received erroneous discount information from Coalition or similar entities. *Id.* ¶ 46. United fully paid the principal amount due for most of the 295 benefit claims before trial. *Id.* ¶ 52.

When United processed each of the 295 benefit claims, it provided Petitioners with an explanation-of-benefits notice ("EOB") that described how it processed the benefit claim and determined the amount due for the benefit claim. United's App. ¶ 48. As a matter of standard business practice, Petitioners reviewed EOBs that they received from United and other administrators to make sure that benefit claims were paid correctly. Pet. App. 57a-58a. When discounts were taken on benefit claims, the EOBs that Petitioners received from United explained why those discounts were taken. United's App. ¶¶ 50-51. By reviewing the EOBs, Petitioners were immediately able to determine how United processed the benefit claims and to identify any specific errors in United's processing. Pet. App. 57a-58a.

Petitioners did not rely on any express or implied assertions in the EOBs that discounts described therein were correctly taken. Pet. App. 57a-58a. Instead, when such provider network discounts were incorrect, Petitioners immediately knew that the

discounts were incorrect, advised United, and demanded from United the additional monies that Plaintiffs believed were due for the benefit claims. *Id.*

In their petition (p. 5), Petitioners assert that United's "improper processing was concealed by the misstatements of United on the EOBs it submitted to Signature" and that "United implemented a computer system which was (a) designed to improperly process the healthcare reimbursement codes submitted by Petitioners to Defendant for reimbursement and (b) mislead the healthcare provider through the use of misstatements on United's EOBs." Petitioners' assertions are not supported by any record citations and are contrary to the district court's factual findings and their own stipulated facts (discussed above). The district court expressly found: "Defendant's actions, although improper, were clearly explained on the EOB's." Pet. App. 58a.

B. Petitioners' lawsuit

Petitioners sued United on account of the errors in United's processing of the 295 benefit claims at issue. Petitioners originally filed this action in the Circuit Court of St. Louis County, Missouri, on April 30, 2004. United removed the case to the United States District Court for the Eastern District of Missouri on May 27, 2004 because 289 of the benefit claims at issue arose under ERISA-governed plans, thereby providing federal question jurisdiction under 28 U.S.C. § 1331 based on ERISA's complete

preemption of Petitioners' state law claims. Pet. App. 1a, 19a.

In their amended complaint, Petitioners asserted causes of action for breach-of-contract, violation of the Missouri Payment-of-Claims Statute (Mo. Rev. Stat. § 376.383), unjust enrichment, violation of the Missouri Vexatious Refusal to Pay Statute (Mo. Rev. Stat. § 375.420), civil RICO (18 U.S.C. § 1964), and ERISA (29 U.S.C. § 1001 *et seq.*). Pet. App. 1a-2a, 31a-58a. Before trial, Plaintiffs conceded that ERISA preempted their unjust enrichment and vexatious refusal to pay claims. Pet. App. 32a. United conceded the principal amount ($28,874.04) that was still due to Plaintiffs on the 295 benefit claims as of the date of trial. Pet. App. 45a. The district court held a non-jury trial on May 16-17, 2006. Pet. App. 32a.

C. The district court's dismissal of Petitioners' civil RICO claim

Because Petitioners' petition for a writ of certiorari is limited to Petitioners' civil RICO claim, a brief discussion of the elements of a civil RICO claim is in order. Petitioners' civil RICO claim was based on 18 U.S.C. § 1962(c). With a § 1962(c) claim, the plaintiff must prove that the defendant "engaged in (1) conduct (2) of an enterprise (3) through a pattern (4) of racketeering activity." *Asa-Brandt, Inc. v. ADM Investor Servs., Inc.*, 344 F.3d 738, 752 (8th Cir. 2003). Satisfying the "racketeering activity" element of RICO requires proof that the defendant committed

one of the "predicate offenses" listed in 18 U.S.C. § 1961(1).

In this case, the predicate offense alleged by Petitioners was mail fraud, as described in 18 U.S.C. § 1341. Specifically, Petitioners claimed that United committed mail fraud when it mailed EOBs to Petitioners that mistakenly treated Dr. Schoedinger as an in-network provider or otherwise applied erroneous provider discounts to his services. In order to establish the predicate act of mail fraud, Petitioners had to prove "the existence of a plan or scheme to defraud, that it was foreseeable that the . . . scheme would cause the mails to be used, and . . . the use of the mails." *Atlas Pile Driving Co. v. DiCon Fin. Co.*, 886 F.2d 986, 991 (8th Cir. 1989); *see also* 18 U.S.C. § 1341. Moreover, Petitioners had to prove a material falsehood: "[M]ateriality of falsehood is an element of the federal mail fraud, wire fraud, and bank fraud statutes." *Neder v. United States*, 527 U.S. 1, 25 (1999). As the court of appeals noted, "the only allegedly material falsehoods claimed by Plaintiffs were the incorrect EOBs." Pet. App. 12a.

In addition to these elements, the civil RICO statute limits standing to bring a claim to those who were injured "by reason of" the defendant's racketeering activity. 18 U.S.C. § 1964(c). This "by reason of" language not only requires the plaintiff to show that the defendant's racketeering activity was the "but for" cause of its injury, but the proximate cause as well. *Holmes v. Sec. Investor Prot. Corp.*, 503 U.S. 258, 268 (1992).

At the close of Petitioners' case (on May 17, 2006), United moved pursuant to Federal Rule of Civil Procedure 52(c) for judgment on partial findings as to several of Petitioners' claims, including their civil RICO claim. The district court granted United's motion in part and dismissed the civil RICO claim, ruling orally that Petitioners failed to provide sufficient factual evidence to support their RICO claim. Pet. App. 9a, 32a. The district court took the remainder of Plaintiffs' claims under submission after the close of United's case.

In a memorandum and order filed several days thereafter (on May 22, 2006), the district court reiterated its finding "that Plaintiffs failed to state a prima facie claim under RICO" and adopted one of several arguments that United raised against Petitioners' civil RICO claim. Pet. App. 56a. Specifically, the district court concluded that Petitioners had not established the proximate causation requirement of a civil RICO claim because Petitioners' witnesses admitted that Petitioners did not detrimentally rely upon the allegedly fraudulent EOBs that they received from United and upon which they based their civil RICO claim. Pet. App. 57a-58a. The district court's conclusion was consistent with the Eighth Circuit's holding in *Appletree Square I, Ltd. Partnership v. W.R. Grace & Co.*, 29 F.3d 1283, 1286-87 (8th Cir. 1994), which held that a plaintiff asserting a RICO claim predicated upon acts of mail or wire fraud must show detrimental reliance on the

defendant's alleged misrepresentations in order to establish proximate causation.

D. The district court's resolution of Petitioners' other claims

On November 6, 2006, the district court ruled on Petitioners' remaining claims. Pet. App. 31a-55a. It rejected Petitioners' state law breach-of-contract claim as to the 289 ERISA benefit claims. Pet. App. 38a-40a. The district court held that ERISA preempted Petitioners' claims under the Missouri's Payment-of-Claims Statute as to the 289 ERISA benefit claims. Pet. App. 40a-43a. The district court awarded Petitioners damages under their ERISA claim for the 289 ERISA benefit claims and under their state law breach of contract claim for the 6 non-ERISA benefit claims. Pet. App. 45a-48a. The district court also awarded Plaintiffs' attorney's fees and prejudgment interest, but denied Plaintiffs' request for permanent injunctive relief. Pet. App. 45a-49a. The final judgment awarded Plaintiffs: (1) $28,874.04 for the principal amount due and owing for the 289 ERISA benefit claims; (2) $4,768.62 for interest on the six non-ERISA benefit claims; and (3) prejudgment interest, attorney's fees, and costs in the amount of $284,261.47. Pet. App. 15a.

E. Petitioners' appeal

Petitioners appealed to the United States Court of Appeals for the Eighth Circuit. Among other issues,

Petitioners challenged the district court's dismissal of their civil RICO claim at the close of their case.

While Petitioners' appeal was pending, this Court issued its decision in *Bridge v. Phoenix Bond & Indem. Co.*, 128 S.Ct. 2131, 170 L.Ed.2d 1012, 553 U.S. ___ (2008). In *Bridge*, this Court addressed whether a plaintiff asserting a civil RICO claim based on a predicate act of mail fraud must demonstrate "first-party reliance" – i.e., that the plaintiff itself, rather than some third party, relied upon the defendant's alleged misrepresentations. In that case, the plaintiffs were bidders at public auctions where a county sold its tax liens on delinquent taxpayers' property. The defendants were competitors of the plaintiffs and allegedly obtained a disproportionate share of the tax liens, to the plaintiffs' detriment, by making misrepresentations to the county about the defendants' compliance with the county's bidding rules. The plaintiffs brought a civil RICO claim against the defendants, alleging that the defendants had engaged in a pattern of mail fraud by lying to the county.

The district court dismissed the civil RICO claim because the plaintiffs had not relied on the defendants' alleged misrepresentations to the county. This Court held that such first-party reliance is not required to establish proximate causation in a civil RICO case. 128 S.Ct. at 2143-45. However, this Court also unequivocally recognized that a civil RICO claim cannot succeed unless someone – either the plaintiff or an involved third party (such as the county in the

Bridge case) – relied upon the defendant's alleged misrepresentations:

> Of course, none of this is to say that a RICO plaintiff who alleges injury "by reason of" a pattern of mail fraud can prevail without showing that *someone* relied on the defendant's misrepresentations. . . . In most cases, the plaintiff will not be able to establish even but-for causation if no one relied on the misrepresentation. . . . In addition, the complete absence of reliance may prevent the plaintiff from establishing proximate cause.

Id. at 2144 (emphasis in original); *see also id.* at 2143 n.6 ("Of course, a misrepresentation can cause harm only if a recipient of the misrepresentation relies on it.").

As for Petitioners' appeal in the present case, the court of appeals affirmed the district court's judgment in all respects. Pet. App. 1a-14a. As for Petitioners' civil RICO claim, the court of appeals noted that the district court's legal "conclusion that lack of detrimental reliance was, by itself, fatal to Plaintiffs' RICO claim was overruled by the subsequent decision in *Bridge*." Pet. App. 11a-12a. However, the court of appeals held that the district court's dismissal of Petitioners' RICO claim could be affirmed on two alternative legal grounds based on the district court's factual findings, which were not clearly erroneous. Pet. App. 12a. Citing the district court's finding that "Defendant's actions, although improper, were clearly

explained on the EOB's," the court of appeals held that Petitioners failed to establish a material falsehood, and that Petitioners failed to prove any intentional deceit by United, and there was "no proper basis to assume such intentional fraud." Pet. App. 12a-13a. The court of appeals observed:

> In this case, the only alleged material falsehoods claimed by Plaintiffs were the incorrect EOBs. But as the district court found, the EOBs were what they purported to be – truthful disclosures of discounts applied in determining what covered benefits United was paying. Plaintiffs concede that the EOBs clearly explained United's justifications for the underpayments.
>
> It is not a scheme to defraud to adopt as a claims policy, "When in doubt, apply the discount and truthfully disclose it."

Pet. App. 12a.

REASONS FOR DENYING THE PETITION

1. The court of appeals' decision does not conflict with *Bridge*.

A. The court of appeals did not fail to follow *Bridge*, but affirmed the district court's dismissal of Petitioners' civil RICO claim based on alternative legal reasons that are unrelated to *Bridge*.

In their first question presented for review, Petitioners assert that the court of appeals failed to

follow this Court's decision in *Bridge*, discussed above. This is simply untrue. As set forth above, the court of appeals noted that one of the district court's expressed bases for dismissing Petitioners' civil RICO claim – that Petitioners did not show their detrimental reliance on the incorrect EOBs – was "overruled by the subsequent decision in *Bridge*." Pet. App. 11a-12a. The court of appeals did not affirm the district court's dismissal on that erroneous basis notwithstanding *Bridge*.

Instead, the court of appeals affirmed the district court on alternative legal grounds supported by the record. The court of appeals found that the district court's finding that "Defendant's actions, although improper, were clearly explained on the EOB's" was not clearly erroneous. Based on that factual finding, the court of appeals held that the district court's dismissal was correct because Plaintiffs had failed to establish a material falsehood or any intentional deceit by United, both of which were elements of the mail fraud predicate of Petitioners' civil RICO claim. *Bridge* does not even remotely touch upon these two alternative legal grounds for affirming the district court's dismissal. *Bridge* dealt with the issue of reliance on a defendant's alleged misrepresentations, not the issues of the materiality of the alleged misrepresentations or the defendant's intent.

Thus, Petitioners are simply mistaken when they contend that "the Circuit Court affirmed the District Court's reliance upon non-viable precedent" or suggest that the court of appeals "affirmed the dismissal

of their civil RICO claim for lack of reliance upon United's false and misleading statements." Petition, pp. 13-14. The court of appeals did no such thing.

Petitioners are apparently under the misapprehension that the court of appeals could not affirm the district court's dismissal of their civil RICO claim based on alternative legal grounds supported by the record. This Court has long held that "[i]n the review of judicial proceedings the rule is settled that, if the decision below is correct, it must be affirmed, although the lower court relied upon a wrong ground or gave a wrong reason." *Helvering v. Gowran*, 302 U.S. 238, 245 (1937).

B. The court of appeals could have affirmed the district court's dismissal of Petitioners' civil RICO claim based on *Bridge* because no one relied upon United's erroneous explanation of benefits (EOB) notices.

Although the court of appeals affirmed the district court's dismissal on alternative legal grounds that have nothing do with *Bridge*, the court of appeals could have affirmed the district court's dismissal based on *Bridge* because it is undisputed that *no one* relied upon United's erroneous EOB notices. In *Bridge*, this Court noted: "Of course, none of this is to say that a RICO plaintiff who alleges injury 'by reason of' a pattern of mail fraud can prevail without showing that *someone* relied on the defendant's misrepresentations." 128 S.Ct. at 2144

(emphasis in original). In *Bridge*, this "someone" existed as the plaintiffs alleged that the county had relied on the defendants' misrepresentations to the county about the defendants' compliance with the county's bidding rules.

Here, Petitioners concede that they did not rely upon United's erroneous EOB notices, and Petitioners presented no evidence that anyone else relied upon the EOB notices. Thus, even under *Bridge*, Petitioners failed to establish the proximate causation element of their civil RICO claim, just as the district court concluded.

2. The court of appeals properly construed the district court's factual findings, but even if it did not, that would not be a basis for granting certiorari.

In their second question presented for review, Petitioners contend that the court of appeals "misapprehended findings of fact of the District Court," "made itself a finder of fact," and "relied upon findings of the District Court stripped of context and made prior to the close of all evidence." Petition, pp. 8, 11, 14. Petitioners' contention, even if true, is not a basis for granting certiorari as Supreme Court Rule 10 provides that "[a] petition for a writ of certiorari is rarely granted when the asserted error consists of erroneous factual findings. . . ."

In any event, the court of appeals properly construed the district court's factual findings and did

not assume the role of fact finder. Indeed, in its opinion, the court of appeals relied on and quoted the district court's core factual finding that "Defendant's actions, although improper, were clearly explained on the EOB's." Pet. App. 12a. The court of appeals based its decision on that factual finding by the district court and did not make any factual findings of its own.

Petitioners insist that the court of appeals "mistakenly believed that the EOBs were truthful." Petition, p. 15. But Petitioners *stipulated* to the facts that confirm that the EOBs were truthful:

> 48. When United processed the benefit claims at issue submitted by Plaintiffs, it provided Plaintiffs with explanation of benefits ("EOB") forms that described how it processed the benefit claims and determined the amount due for the benefit claims.
>
> 49. The EOBs that Plaintiffs received from United explained when United "bundled" a benefit claim.
>
> 50. When discounts were taken on benefit claims, the EOBs that Plaintiffs received from United explained why those discounts were taken.
>
> 51. The EOBs for the benefit claims at issue explained when United applied an out-of-network pricing discount based on information that United received from Coalition, identified the "rented" provider network under which the discount was applied, and

> specifically advised Plaintiffs to contact Coalition if they had any issue with the discount.

United's App. ¶¶ 48-51. As both the district court and the court of appeals concluded, the EOBs were truthful because they fully disclosed the erroneous actions (e.g., erroneous discounts) that United took when it incorrectly processed the benefit claims at issue. While Petitioners now argue that "United's EOB's were misleading," Petition, p. 19, they previously "concede[d] that the EOBs clearly explained United's justifications for the underpayments." Pet. App. 12a.

Petitioners take out of context other findings by the district court that the EOBs contained "misstatements" and "faulty statements." The district court was merely observing that the EOBs did not correctly state the amounts due to Petitioners for the benefit claims at issue. These observations do not alter the district court's conclusion – supported by Petitioners' stipulated facts – that the EOBs clearly and truthfully explained how United arrived at the incorrect amounts due such that Petitioners could readily challenge and seek correction of United's errors.

Finally, Petitioners complain that the court of appeals ignored the district court's factual findings that "United's claims processing system was flawed" and that "Plaintiffs provided evidence of Defendant's wanton behavior" in not remedying claims processing

errors caused by United's computer system. These findings do not contradict the district court's key finding that the EOBs clearly explained United's actions. Nor do they undermine the court of appeals' conclusion that Petitioners failed to establish a material falsehood or any intentional deceit by United, both of which were necessary elements of Petitioners' civil RICO claim.

CONCLUSION

The court of appeals' decision raises no issues worthy of review by this Court. There is no conflict with *Bridge*, and the court of appeals' decision is consistent with the district court's factual findings. This Court, therefore, should deny the petition for a writ of certiorari.

Respectfully submitted,

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August 21, 2009

RESPONDENT'S APPENDIX

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

GEORGE SCHOEDINGER, M.D., and SIGNATURE HEALTH SERVICES, INC.,	)	
Plaintiffs,	)	Case No. 04CV00664SNL
v.	)	
UNITED HEALTHCARE OF THE MIDWEST, INC.,	)	
Defendant.	)	

JOINT STIPULATION OF UNCONTESTED FACTS

Plaintiffs George Schoedinger, M.D. and Signature Health Services, Inc. and Defendant United HealthCare of the Midwest, Inc. stipulate to the following uncontested facts for the purposes of the present action only:

1. Plaintiff Signature Health Services, Inc. ("Signature") is a Missouri corporation that employs physicians in a number of fields, including orthopedics, obstetrics and gynecology, physiatry, radiology, and allergy.

2. George Schoedinger, M.D. ("Dr. Schoedinger") is an orthopedic surgeon employed by Signature.

3. Dr. Schoedinger has authorized Signature to bill and collect on his behalf for the medical services that he provides to his patients.

4. Defendant United HealthCare of the Midwest, Inc., is a Missouri corporation.

5. United HealthCare of the Midwest, Inc., and its affiliates (collectively, "United") administer health plans sponsored by various employers.

6. United HealthCare of the Midwest, Inc., is a wholly-owned subsidiary of UnitedHealthcare, Inc., which is a wholly-owned subsidiary of United HealthCare Services, Inc., which is a wholly-owned subsidiary of UnitedHealth Group Incorporated.

7. Uniprise Incorporated ("Uniprise") is an affiliate of United. Uniprise and its affiliates process benefit claims submitted to United under the various health plans administered by United.

8. Uniprise is a wholly-owned subsidiary of United HealthCare Services, Inc., which, as discussed above, is the indirect parent company of United HealthCare of the Midwest, Inc.

9. Like United HealthCare of the Midwest, Inc., and its affiliates, Uniprise is indirectly a wholly-owned subsidiary of UnitedHealth Group Incorporated.

10. Before April 15, 2003, Dr. Schoedinger had a participating provider agreement with United.

11. Under this contract, Dr. Schoedinger was a "participating" or "in-network" provider for United and agreed to accept an agreed upon amount that was typically lower than the amount of his billed charges as payment in full for services rendered to patients covered under health plans administered by United.

12. Dr. Schoedinger terminated his agreement with United effective April 15, 2003.

13. Since Dr. Schoedinger stopped being a network provider on April 15, 2003, Dr. Schoedinger has had no written contract with United.

14. Since Dr. Schoedinger stopped being a network provider effective April 15, 2003, Dr. Schoedinger has had no written contract with United.

15. Since his termination of his physician participation agreement with United, Dr. Schoedinger (through Signature) has submitted numerous benefit claims to United for services that he rendered to patients covered under health plans administered by United.

16. Dr. Schoedinger requires payment up front from his patients unless they have signed an assignment of benefits in his favor and he will not bill the patients' insurers unless the patients have executed an assignment of benefits in his favor.

17. Plaintiffs' lawsuit concerns the processing by United of 295 benefit claims that Dr. Schoedinger (through Signature) submitted for services that he

rendered to patients covered under health plans administered by United.

18. The 295 benefit claims at issue arise under various health plans that are maintained by the patients' employers for the purpose of providing medical benefits to their employees.

19. These health plans are "Employee Welfare Benefit Plan[s]" under the Employment Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, because they are maintained by the patients' employers for the purpose of "providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or daycare centers, scholarship funds, or prepaid legal services . . . " 29 U.S.C. § 1002(1).

20. 289 of the 295 benefit claims at issue arise under health plans that are covered by ERISA.

21. The remaining 6 benefit claims at issue arise under health plans that are not covered by ERISA.

22. Of the 289 benefit claims that arise under ERISA health plans, 268 benefit claims arise under ERISA health plans that are self-funded or self-insured, which means that the plan sponsors (i.e., employers) are financially liable for the benefits due to plan participants and United's sole role is to

perform third-party administrative and claims processing services in accordance with the terms of the plans and United's administrative services agreements with the plan sponsors.

23. Of the 289 benefit claims that arise under ERISA health plans, 21 benefit claims arise under ERISA health plans that are fully-insured by United, which means that in addition to performing administrative and claims processing services, United is also financially liable for the benefits due to plan participants.

24. Most of the 295 benefit claims at issue involve patients who are railroad employees or dependents of railroad employees and are covered by the railroad health plans.

25. The railroad health plans are self-funded ERISA plans for which United provides third-party administrative and claims processing services pursuant to United's contracts with the railroad health plans.

26. While United pays benefit claims arising under the railroad health plans, it does so on behalf of the railroad health plans, which, as self-funded plans, are ultimately liable for the benefit claims.

27. Coalition America, Inc. ("Coalition"), is a company that has agreements with a number of entities that maintain provider networks.

28. These entities have agreements with providers whereby the providers agree to accept discounted amounts from their billed charges as the allowable charges for their services.

29. Under such agreements, the allowable charge is the amount for which the patient is liable and from which benefits payable under a health plan are calculated. For example, assume that a patient has a health plan that pays 60 percent of reasonable and customary charges (i.e., allowed charges), that a physician's billed charges for services to the patient are $100, and that the physician has an agreement with some entity to accept $80 as the allowed charge for his services, and that the health plan can access that agreement between the physician and the entity. In such circumstances, the health plan will pay $48 for the services (60 percent of $80) and the patient will be liable to the physician for the remaining $32 ($80 less $48).

30. These entities effectively "rent" their provider networks to Coalition pursuant to agreements between the entities and Coalition.

31. In turn, Coalition makes these "rented" provider networks available to health plans pursuant to agreements between Coalition and the health plans.

32. Coalition has its own separate contract with the railroad health plans that allows the railroad health plans to access and obtain the benefits of Coalition's "rented" provider networks.

33. There is no written contract between Coalition and United.

34. United has no dealings with Coalition other than through United's processing of benefit claims arising under the railroad health plans, discussed below.

35. As discussed above, United provides third-party administrative and claims processing services for the railroad health plans pursuant to United's contracts with the railroad health plans.

36. If a patient covered under the railroad health plans obtains medical services from a United in-network provider, then United pays the benefit claim in accordance with the fee provisions of its provider agreement with the in-network provider, subject to the terms of the railroad health plans.

37. In such circumstances, the benefit claim is not sent to Coalition for pricing.

38. If a patient covered under the railroad health plans obtains medical services from an out-of-network provider, United first determines whether benefits are payable under the railroad health plans. If so and the benefit claim meets certain criteria (primarily, that the benefit claim exceeds $100), then United is ***required*** by the railroad health plans under United's contract with the railroad health plans to send the benefit claim to Coalition for pricing of the benefit claim.

39. If Coalition has access to a "rented" provider network under which it can invoke a discount, Coalition so advises United and tells United the amount of the discount and allowable charge for the benefit claim. United then pays the benefit claim based on the pricing information that it receives from Coalition, subject to the terms of the railroad health plans.

40. In such circumstances, the railroad health plans, through United as the transaction agent, pay a fee to Coalition based on the savings obtained by Coalition for the railroad health plans.

41. If Coalition advises United that it does not have access to any discount for the benefit claim, then United processes the benefit claim based on the lower of billed charges or reasonable and customary charges, subject to the terms of the railroad health plans.

42. All benefits claims processing is done by United and its affiliates; Coalition does no claim processing on United's behalf and does not pay benefit claims.

43. United, not Coalition, determines whether a benefit claim arising under the railroad health plans should be paid or denied.

44. Plaintiffs allege that United processed the 295 benefit claims at issue incorrectly and improperly, has not paid them the amount of benefits due under the patients' health plans for these benefit

claims, and/or has not made timely payments to them for these benefits claims.

45. Plaintiffs allege that United incorrectly processed and underpaid some of the benefit claims by incorrectly continuing to treat Dr. Schoedinger as a United in-network provider after he terminated his participating provider agreement effective April 15, 2003.

46. Plaintiffs allege that United incorrectly processed and underpaid some of the benefit claims by incorrectly applying out-of-network pricing discounts based on erroneous information that United received from Coalition for benefit claims arising under the railroad health plans or from another unrelated entity, BCE Emergis, for benefit claims arising under other health plans. Plaintiffs further allege that the incorrect discounting continued after United was advised of the problem by Plaintiffs.

47. Plaintiffs allege that with some benefit claims, United improperly "bundled" two or more separate medical procedures, meaning that United treated two or more procedures as one procedure and paid for the one "bundled" procedure instead of paying for each of the procedures separately.

48. When United processed the benefit claims at issue submitted by Plaintiffs, it provided Plaintiffs with explanation of benefits ("EOB") forms that described how it processed the benefit claims and determined the amount due for the benefit claims.

49. The EOBs that Plaintiffs received from United explained when United "bundled" a benefit claim.

50. When discounts were taken on benefit claims, the EOBs that Plaintiffs received from United explained why those discounts were taken.

51. The EOBs for the benefit claims at issue explained when United applied an out-of-network pricing discount based on information that United received from Coalition, identified the "rented" provider network under which the discount was applied, and specifically advised Plaintiffs to contact Coalition if they had any issue with the discount.

52. United has fully paid the principal amount due for most of the 295 benefit claims at issue.

Respectfully submitted,

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